

二零一二年一月九日  
資料文件

## 立法會衛生事務委員會

### 公立醫院醫療事故的處理

#### 目的

本文件向委員闡述公立醫院處理醫療事故的機制，以及醫院管理局(醫管局)相關的臨床管治架構。

#### 公立醫院處理醫療事故的機制

2. 醫管局一向非常重視其服務質素及病人安全，並設有既定制度及指引及呈報和處理醫療事故。醫管局自二零零四年起引入名為「醫療事故匯報系統」的電子系統，讓前線員工可以在工作地點的電腦直接呈報事故，從而令醫院能及早採取行動，支援涉及事件的員工和病人。
3. 二零零七年十月，醫管局參照國際做法，推行嚴重醫療事故呈報政策，規定有九類事故須予呈報；並劃一嚴重事故的定義和統一公立醫院呈報、調查和處理這些事故的程序。醫管局在二零一零年一月進一步改善醫療事故的呈報機制，規定有多兩類重大風險事件須予呈報，分別是可導致死亡或永久受損的錯誤處方藥物和錯辨病人身份事件。在嚴重醫療事故及重大風險事件政策下須予呈報的醫療事件載於附件一。
4. 根據該政策，公立醫院須在二十四小時內透過醫療事故匯報系統向醫管局總辦事處呈報所有嚴重事故及重大風險事件，並根據既定程序予以處理。透過上述安排，我們旨在減少對涉及事件的病人、家屬及員工的傷害及為他們提供所需支援；以及鼓勵公開披露有關事件。
5. 每宗嚴重醫療事故及重大風險事件均會交由醫管局委任的專家小組調查，以找出可能導致事故的成因，並研訂改善措施。涉事醫院會於八星期內向醫管局總辦事處提交正式報告。有關改善措施會在醫院層面推行，以避免類似事件再次發生；而醫管局總辦事處則會按情況在機構層面統籌推行改善有關制度和工作程序的措施。

## 醫管局嚴重醫療事故及重大風險事件的統計數字

6. 醫管局總辦事處每年向醫管局大會提交嚴重醫療事故報告，並向公眾公開報告。在內部方面，醫管局透過員工培訓以及每三個月出版的《風險通報》通訊，讓醫護人員互相分享處理醫療事故的經驗。最新一期《風險通報》現載於**附件二**(只有英文版本)。

7. 在二零一零年十月一日至二零一一年九月三十日的 12 個月內，經呈報的嚴重醫療事故共有 44 宗，重大風險事件則共有 97 宗。有關統計資料載於**附件三**。

## 醫管局臨床管治架構

8. 爲了維持護理服務的水準和持續改進其服務質素及專業問責，醫管局自成立以來已設有一個臨床管治架構。

9. 在醫生服務方面，醫管局引入臨床管理小組及部門主管的架構，著重由專科醫生領導提供服務，以及由同業進行臨床能力評審。各臨床部門的專科醫生負責向初級醫生提供培訓、指導及直接督導，從而確保專業水平。各臨床部門的主管則負責維持部門的臨床服務質素，並向醫院最高管理層負責。護士及專職醫療人員亦設有類似的專業督導和培訓框架。

10. 醫管局亦在公立醫院及聯網成立了質素及安全隊伍，在臨床人員之間推廣保障病人安全的文化及推行風險管理及改善服務質素的計劃。當有醫療事故呈報時，有關聯網的質素及安全隊伍會採取所需行動評估風險、支援事故調查，及統籌醫管局內部與外部持份者的溝通。

11. 醫管局多年來亦透過推行各項措施及計劃，確保服務水平和持續改進服務質素。這些措施及計劃包括臨床審核、監察及改善外科服務成效的計劃、醫院評審先導計劃、引進新醫療科技及藥物的機制，以及醫管局監管研究倫理的內部機制。醫管局亦設立了一個兩層投訴處理制度，跟進病人的意見及找出可改善之處。醫管局的臨床管治機構結合上述的各項措施，能就不同醫院的表現提供適時資料，有助比較及改進醫管局的服務。

## 檢討醫管局的臨床管治

12. 良好的臨床管治是提供優質醫療服務的基礎。醫管局已計劃參照國際最高標準，檢討其臨床管治系統；以期把握機會進一步強化公立醫院的臨床管治。有關檢討將於二零一二年初展開。

## 支援提供優質服務的資源及人手

13. 除了設立有效的臨床管治架構外，醫管局亦會確保有足夠的資源和人手，以支援優質服務的提供。醫管局在分配資源予各聯網時會考慮一系列因素，當中包括各區的人口增長及人口結構轉變、病人跨聯網求診(即病人向不屬其所居住地區的醫院／診所求診)的影響、以及在推行新服務計劃、紓緩區內服務壓力、提供員工培訓及購買設備及藥物等方面所需的資源。醫管局在分配內部資源時，亦會參考不同醫院在併發疾病及複雜個案方面不同的病例組合。

14. 在人手方面，醫管局一直密切監察各專業及專科的醫護人員人力情況，以確保有足夠人手應付服務需求。醫管局醫生、護士及專職醫療人員的人手由二零零六至零七年度至二零一零至一一年度期間分別增加了 8.1%、4.6%及 13.1%。護理支援人員的數目在同期間亦增加了約 26%。各聯網的整體人手在過去數年均有增長。

15. 由於人口增長及老化導致需求及病人數目增加，醫管局目前面對人手緊張的情況。私營醫療界急速發展亦吸引了醫護人員離開公營醫療系統。醫管局已投入額外資源以推行一系列措施以吸引和挽留人手。這些措施包括提高薪酬待遇、改善工作環境、增加晉升及培訓機會等。為增加醫生人手，醫管局正積極招聘本地全職及兼職醫生，並計劃招聘有限度註冊的非本地醫生。在護士人手方面，隨着醫管局護士學校學額及本地大學畢業生人數增加，醫管局能在今年及未來數年招聘更多護士。

## 徵詢意見

16. 請委員閱悉本文件內容。

食物及衛生局  
醫院管理局  
二零一二年一月

在醫管局嚴重醫療事故及重大風險事件政策下  
須呈報的事件類別

嚴重醫療事故

1. 錯誤為病人或某身體部位進行外科手術／介入手術程序
2. 進行外科手術／介入手術程序後在病人體內遺留工具或其他物料
3. 進行 ABO 血型不配合的輸血
4. 錯誤處方藥物引致病人永久喪失主要功能或死亡
5. 因出現血管內氣體栓塞而導致病人死亡或神經損害
6. 住院病人自殺死亡(包括當時正暫時返家休養的病人)
7. 在分娩過程或生產時發生嚴重事件引致孕婦死亡
8. 錯配初生嬰兒或發生擄拐嬰兒事件
9. 導致病人永久喪失功能或死亡的其他嚴重事件(不包括併發症)

重大風險事件

1. 可導致病人死亡或永久受損的錯誤處方藥物事件
2. 可導致病人死亡或永久受損的錯辦病人身份事件



## IN THIS ISSUE

### § Sentinel Events (Q2 2011)

- Retained gauze / consumables / dressing material
- Patient suicide

### § Serious Untoward Events (Q2 2011)

### § Sharing

- Distribution of SEs & SUEs (Q2 2011)
- Good practice on preventing the leaving of tourniquet or disposable glove on patients
- HARA for learning and sharing
- Top reported categories of incidents in AIRS (Q1 – Q2 2011)

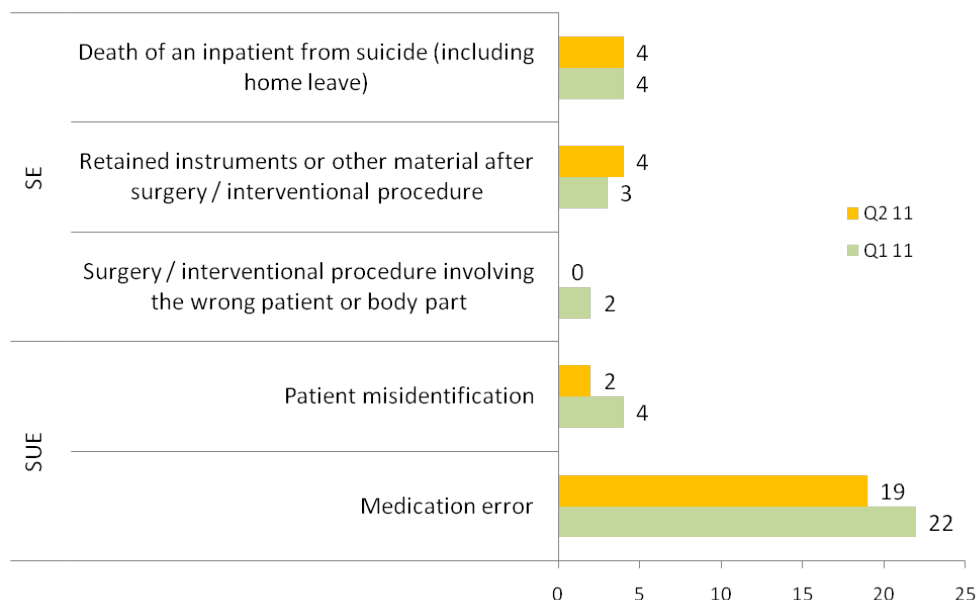
### A Physician's Perspective on Medication Safety

Medication prescription is an integral process in the practice of internal medicine. To be effective and safe, medications need to be prescribed and administered correctly in the right dosage. As most of the patients have multiple chronic medical conditions requiring long-term treatment, polypharmacy is a common issue. A large proportion of the patients are elderly and dependent and may not be familiar with the individual drugs that they are taking. With the large number of medication prescription and administration transactions in the busy ward and clinic environment, medical and nursing staff need to be vigilant about the potential for medication errors.

It is important to reinforce the safety check measures when medical and nursing staff are prescribing and administering medications. However, it would be necessary to recognize that these measures impose additional workload and it is understandable if the clinical staff experience performance fatigue with repetitive action on a prolonged duration under time constraint. While they should be reminded of the risk of medication incidents, the control measures should focus on high-risk drugs with serious consequence. More automatic system safeguards making use of information technology should be introduced to reduce reliance on manual performance by the staff. Implementation of medication unit dosing for in-patients would reduce the burden on the nursing staff in drug administration. Clinical pharmacy service would provide invaluable support to the busy ward staff in preventing medication incidents. Medication administration practices should be aligned within hospitals and clusters. Frequent change of generic brands should be avoided to reduce confusion to the frontline medical and nursing staff. Clinicians should also periodically review the medication profile of their patients and discontinue those which were either actually not taken by the patients or no longer clinically necessary.

**Dr. Patrick LI, Chairman, COC, Internal Medicine**

### DISTRIBUTION OF SENTINEL (SEs) & SERIOUS UNTOWARD EVENTS (SUEs) (Q2 2011)



**Case 1: Raytec gauze**

- Emergency caesarean hysterectomy was performed on a patient with massive post-partum haemorrhage.
- Two scrub nurses assisted the operation while two circulating nurses counted off and weighed the bags of blood-soaked gauzes to estimate blood loss.
- The scrub nurse and a circulating nurse did the final surgical counting before wound closure (including counting the number of *tied-up gauzes already put away in the bags*). No discrepancy was detected.
- The mother and baby were discharged after 5 days.
- The mother was admitted via A&E for left loin pain 9 months later.
- Plain abdominal x-ray and CT scan showed a 2.4 x 5.6 x 6.5cm shadow, with hyper dense line suggestive of a retained gauze in the right iliac fossa of the patient.
- A long raytec gauze was removed in a subsequent elective laparoscopic operation.
- The patient's recovery was uneventful after the operation.

**Key Contributing Factors:**

1. Failure to conduct final count of *individual number* of raytec gauzes at the end of the operation.
2. Unclear role delineation among the nurses in surgical counting.

**Recommendations:**

1. To enhance the departmental guideline on surgical counting.
2. To explore the use of "surgical counting system" to ensure proper surgical counting procedure and practice.
3. To consider adopting complementary checking measures in high risk operations.
4. To enhance communication and "speak up" culture among member of the surgical team.

**Case 2: Dressing strip**

- A patient had persistent sinus discharge on the right foot.
- He was followed up at Orthopaedics & Traumatology (O&T) clinic and was also receiving wound care and regular dressing by community nurse. A podiatrist prescribed silver impregnated special dressing strip (three layered gauze) for packing of patient's chronic sinuses by community nurse.
- Four dressing strips were packed into the wound. Subsequently, two dressing strips were removed during consultation in the O&T SOPD.
- The podiatrist switched the prescription of packing material to Betadine gauze. The community nurse continued with the patient's wound dressing and packing.
- One month later, one dressing strip was discovered from a new wound on the lateral aspect of the patient's right foot.
- Exploration of the plantar sinuses was recommended by the attending doctor but was declined by the patient.

**Key Contributing Factors:**

1. Documentation of the number of gauzes packed or removed from the wound had not been included in the operational procedure.
2. Dressing strips with multiple layers were used.

**Recommendations:**

1. To enhance communication between the podiatrist and community nurse, e.g. by using a standard template to document the number of gauze used and removed.
2. To use single layer dressing strips for packing deep wound instead of multi-layer dressing.

### Case 3: Endocap

- An emergency oesophagogastroduodenoscopy (OGD) was performed on a patient with acute oesophageal varices bleeding.
- Endoscopic variceal ligation was performed by using a “Six Shooter” ligator.
- Bleeding stopped and an elective follow-up OGD was done 2 days later.
- A retained endocap was found in the oesophagus and was removed.
- The patient suffered no adverse outcome from the retained endocap.

### Key Contributing Factors:

1. The endocap could not be perfectly fitted onto the endoscope because of size discrepancy.
2. The endoscope was not thoroughly checked after the procedure.
3. Inadequate knowledge and experience of doctors on the equipment and the setting of Endoscopy Unit (EDU).



### Recommendations:

1. To review / develop guideline and reminders for setting up and aftercare of endoscopes, with inclusion of equipment integrity check in the procedure sign out checklist.
2. To conduct EDU orientation course for surgeons and interns utilizing its service.
3. To stock different sizes of endocaps to reduce chance of size discrepancy.

### Case 4: Cut suction catheter

- A patient who was diagnosed with metastatic squamous cell carcinoma of hypopharynx had airway obstruction and tracheostomy done.
- Repeated blockage of tracheostomy tube requiring tube change for four times.
- On the last tube exchange, a suction catheter, after being cut short, was used as an insertion guide.
- Subsequent CT scan of thorax and neck revealed a retained cut tubing in the patient’s left lower lobe bronchus.
- Bronchoscopy was performed to remove the retained fragment.

### Key Contributing Factors:

1. No standard guideline on best practices for tracheostomy tube exchange, particularly relating to the use of insertion guide (including length, material & procedure).
2. No equipment count/check after procedure.

### Recommendations:

1. To implement proper practice when using cut suction catheter as insertion guide for tube exchange by adopting 15 cm above tracheostomy stoma as a minimum length of the cut suction catheter.
2. To enforce proper communication and documentation on all objects used and their count during and after procedures.
3. To provide training and organize sharing session on tracheostomy tube exchange procedure.

## PATIENT SUICIDE

Four inpatients / home leave patients committed suicide in the 2nd quarter of 2011, including 1 psychiatric in-patient, 2 psychiatric patients while on home / day leave and 1 patient with chronic illness who committed suicide outside hospital.

### Recommendations:

1. Beware of the risk in providing patient with items, e.g. power cable, which can be used for hanging..
2. Design washroom to ensure that the partitions are extended up to the ceiling to minimize risk of being used as supporting point for hanging.
3. Alert to significant change in patient’s pain score.

### Conclusions from the RCAs:

1. Difficulty in identifying all at risk psychiatric patients with the existing suicide assessment tool.
2. Suboptimal awareness of severe psychiatric symptoms (such as hallucination) by medical & nursing staff.

Of the 21 cases reported in the second quarter of 2011, 19 were related to medication errors and 2 were related to patient misidentification.

## MEDICATION INCIDENTS INVOLVING KNOWN DRUG ALLERGY

*Case Highlight: Severe Allergy Reaction to Non-Steroidal Anti-Inflammatory Drug (NSAID)*

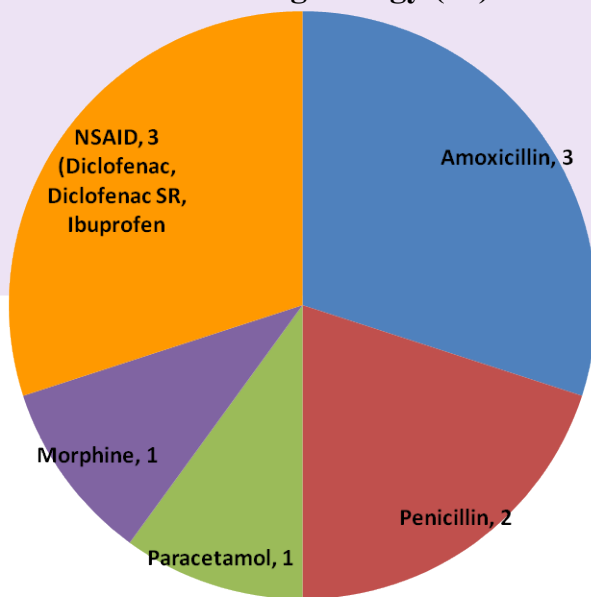
### Case 1:

- A patient attended GOPC for shoulder pain and was prescribed Diclofenac SR.
- Despite “Drug Allergy on NSAID” was printed on the prescription, the drug was dispensed to the patient by the pharmacy.
- Allergy warning was not activated at CMS or the pharmacy system as the allergy information was typed in “free text” mode.
- Patient developed severe acute asthma attack and was admitted to ICU.
- Patient recovered after treatment.

### Case 2:

- A patient attended A&E for back pain.
- The allergy history was not detected at Triage Station.
- A doctor assessed the patient, noted history of drug allergy on CMS and wrote “Penicillin & Ibuprofen” allergy at the corner of AED record sheet.
- The same doctor later prescribed Ketorolac 30mg to the patient for severe back pain.
- A nurse, not aware that Ketorolac was a NSAID, administered the medication.
- The patient developed acute respiratory distress with loss of consciousness and was transferred to ICU for mechanical ventilation.
- Patient recovered after treatment.

**Known Drug Allergy (10)**



### Common Contributing Factors:

1. Lapse of concentration.
2. Inadequate knowledge of different drugs of the same class.
3. Failure to comply with the guideline on drug administration (conduct allergy check).
4. Did not clarify doubtful or illegible information.
5. Inadequate communication among clinical team members.
6. Bypassed (Pharmacy) vetting system.

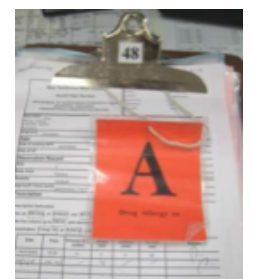
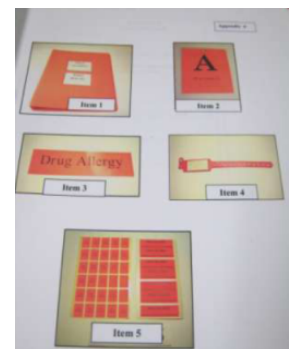
### Useful steps to prevent prescribing & administering drugs with “Known Drug Allergy”

1. Enhance the “known drug allergy” alert and warning display for in-patients.
2. Introduce procedures to prevent inadvertent administration of antibiotics of Penicillin group to patients with “known drug allergy” to Penicillin.



### Other useful measures

1. Use Red Drug Allergy patient wrist band, MAR record folder.
2. Post warning of drug allergy on the wall, and charts.
3. Use common drug class reference card.
4. Minimize ward stock of Penicillin group antibiotics.
5. Require 2 staff (preferably 1 doctor + 1 nurse) to complete the checklist before obtaining the first dose of Penicillin group antibiotics from ward stock.





## MEDICATION INCIDENTS INVOLVING ANTICOAGULANTS

### *Case 1: Prescribed wrong Warfarin dosage*

- A doctor intended to increase Warfarin dosage to 2mg daily but wrongly typed in “5” via the Medication Order Entry (MOE). Warfarin 5mg daily was dispensed to patient.
- Patient took the wrong dose for around 1 month and was subsequently admitted to hospital for Warfarin overdose.
- Patient was discharged home after treatment.

### *Case 2: Omitted prescription of Warfarin on discharge*

- A doctor prepared a discharge prescription in advance leaving out Warfarin because the dose was still being adjusted. The provisional prescription was saved in the computerized system.
- The patient was discharged 2 weeks later. The same doctor forgot to update and check the prescription .

#### **Recommendations for cases 1 & 2:**

1. To check the prescription printout against the MAR before signing.
2. To engage patients/ carers in the disease management process and treatment plan, so that they are aware of medication change.

### *Case 3: Inadvertent infusion of Heparin*

- A doctor entered an order “recheck INR level” and “start Heparin if INR level dropped to <1.5” as an “**indicated condition**” into CMS.
- An intern transcribed the order but omitted the part “start Heparin if INR < 1.5”. Only loading dose of Heparin and the maintenance dose was transcribed into the patient’s MAR.
- A nurse administered the Heparin according to the MAR order without checking the CMS instruction and INR level. The patient’s INR was actually > 1.5 and did not need the Heparin infusion.
- Patient suffered no adverse outcome from this incident.

#### **Recommendations for case 3:**

Clear communication among staff is essential to avoid error especially in cases like “if... then...” orders.

### *Case 4: Heparin infused at the wrong rate*

- A doctor prescribed Heparin infusion at a rate of 750 units/hr (the dilution method would need the setting of the infusion rate at 7.5ml/hr at Syringe Pump).
- Nurse A prepared the Heparin syringe and counter-checked with Nurse B. Both nurses did not counter check with the infusion rate against the standardized “Drug Dilution Table”.
- While setting up the infusion pump, both nurses did not check against the patient’s MAR and wrongly set the infusion rate at 75ml/hr (10 times higher than the prescribed dose).
- Patient’s vital signs were stable and the patient did not complain of any discomfort.

#### **Recommendations for case 4:**

1. To reinforce the practice of double checking of calculated infusion rate and the setting of the infusion rate on the pump by 2 staff for high risk drugs.
2. To make use of standardized Drug Dilution Table for infusion drugs.

## MEDICATION INCIDENTS INVOLVING DANGEROUS DRUG

### *Case 1: Wrong dose of Midazolam*

- A doctor prescribed Midazolam 3mg IV as pre-medication.
- Nurse A checked out 1 vial of Midazolam (15mg/3ml) and counter-checked with the nurse i/c. She then diluted the entire 15mg with normal saline to a final preparation of 15mg/15ml Midazolam.
- Nurse A mistakenly administered the entire content of the syringe (15mg) to the patient.

### *Case 2: Methadone inadvertently administered instead of Pethidine*

- Pethidine 50mg IM was prescribed for post-operative pain.
- Nurse A wrongly took an ampoule of Methadone instead of Pethidine.
- Nurse B only counter-checked the number of remaining ampoules (for documentation) without checking drug identity.
- Nurse A administered Methadone to the patient without a second person check.

#### **Recommendations for cases 1 & 2:**

1. To counter-check the identity and dosage of dangerous drugs (DD) by two nurses before administration.
2. To ensure the correct strength by checking the drug package label and the MAR.
3. To properly label all diluted preparation syringes.
4. To check the drug against the DD register to ensure the right drug and dose being given.

## OTHER MEDICATION INCIDENTS

### Case 1:

- A doctor intended to prescribe Prednisolone and Acyclovir to an end-stage renal failure patient.
- He consulted a renal physician on the adjustment of Prednisolone dosage but not Acyclovir (which should be reduced for renal failure).
- Full dose of Acyclovir 800mg 5 times daily was prescribed.
- The patient was subsequently admitted for dizziness and confusion from Acyclovir toxicity.
- After treatment, patient was transferred to general ward and was given explanation on the incident.

### Contributing Factor:

Knowledge gap in adjusting the dosage of Acyclovir for renal failure patients.

### Recommendation:

To enhance staff awareness of dosage adjustment for renal failure

### Case 2:

- Nurses A and B prepared an infusion for a patient. Nurse A checked the Syntocinon infusion fluid while Nurse B checked the infusion device.
- Nurse B thought the flow rate had been set correctly by Nurse A and did not check against the prescription before starting the infusion device.
- Nurse A assumed Nurse B had checked against the prescription and set the device correctly.
- Syntocinon infusion rate was wrongly set to 125ml/hr instead of 3ml/hr.
- The error was revealed when the fetal heart rate dropped to 80bpm with 14.9ml of Syntocinon already infused.
- Infusion was stopped and the fetal heart rate returned to 140bpm.
- The baby was delivered by vacuum extraction. Conditions of baby and mother were both satisfactory.

### Contributing Factor:

Non-compliance with the guideline of checking the administration of infusion at prescribed rate before signing the MAR.

### Recommendation:

To emphasize the importance of counter-checking the flow rate before commencing the infusion.

### Case 3:

Gliclazide metabolite was detected in the urine of a non-diabetic patient.

### Conclusion

No contributing factor could be established.

## PATIENT MISIDENTIFICATION

### Case 1:

A patient was dispensed 4 wrong medications due to picking up of wrong drug basket by dispensing staff (basket for ticket no. 563 was mistaken for ticket no.553). The prescription was collected by the patient's domestic helper. The patient was subsequently detected with low blood pressure in out-patient clinic.

### Contributing Factors:

- Lapse of concentration
- Misinterpretation between staff and domestic helper.

### Recommendation:

To ensure the correct drugs are dispensed by checking the drug basket ticket number and patient identity.

### Case 2:

A patient with elevated potassium level (5.1 mmol/l) was given extra potassium chloride supplement (10mmol KCL Q8H) by a verbal order due to misfiling of laboratory result from another patient. Rechecked potassium level was 4.4mmol/l.

### Contributing Factor:

Non-compliance with the cross-checking procedure of a patient identification.

### Recommendation:

Need to verify the patient identity on lab report before issuing treatment order.

# SHARING

## GOOD PRACTICE ON PREVENTING THE LEAVING OF TOURNIQUET OR DISPOSABLE GLOVE ON PATIENTS

Tourniquet or disposable glove used as tourniquet were repeatedly left on patients' limbs after blood taking. There are different risk reduction programs or ways to prevent recurrence of similar incidents devised by various hospitals. The following are some examples:



*Safety Designs & Devices*



### Sharing of Good Practice Tips

**NTWC Quality and Safety Division**

**Important message to Houseman**

**NTWC Quality & Safety Flyer**

**為病人抽血時，切勿以即棄膠手套代替抽血帶**  
**Don't use Latex Glove as tourniquet**

我係即棄手套，有保護色「你睇我唔到」好易留係病人手臂上！

我係抽血帶，我雖然粗粗濶濶，但我很溫柔！用完我，記得帶我走呀！

我捆得幼細又緊緻，好易令病人留下深割路印！

**Don't leave me behind!**

**DO NOT**

**DO**

**THIS IS MY HOME**

**iSMART** Safe practice, Good practice  
 Issue 2 4th May 2009

**No Retained Tourniquet, No Regret!**

A tourniquet was left strapped on patient's upper arm for 4 hours after blood taking leading to oedema and bruising

**SMART TIPS**

1. NEVER use tourniquet for haemostasis purposes.
2. ALWAYS remove the tourniquet right after i.v. access or blood taking, and REMIND EACH OTHER.
3. Remove any tourniquet retained on patient's limbs whenever detected.

Healthcare service is a complex process. Unforeseen events will occur. The purpose of iSMART is to alert frontline staff to the risks and to share learning points from adverse incidents reported locally or elsewhere.

**NTWC Q&SDM**

# SHARING

## HARA FOR LEARNING & SHARING

The HA Risk Alert is a rich source of information on clinical risks and risk reduction measures. It is important to learn from the reported incidents. With 23 issues of HARA published, it may not be easy to search a specific type of incidents. The incidents reported in HARA are now indexed (as excel file) to facilitate viewing and searching. The incidents can also be searched by the use of keyword via iGATEWAY provided by NTEC.

To visit HARA and the index file, please access (Thematic View >HAHO >Quality and Safety> HA Risk Alert or use the following link:

<http://qsdportal/psrm/Public/HA%20Risk%20Alert/HA%20Risk%20Alerts%20Index.htm>

Issue	Category	Type	Content
01	Medication	Administration	Medication - wrong site
02	Medication	Administration	Medication - wrong site
03	Medication	Administration	Medication - wrong site
04	Medication	Administration	Medication - wrong site
05	Medication	Administration	Medication - wrong site
06	Medication	Administration	Medication - wrong site
07	Medication	Administration	Medication - wrong site
08	Medication	Administration	Medication - wrong site
09	Medication	Administration	Medication - wrong site
10	Medication	Administration	Medication - wrong site
11	Medication	Administration	Medication - wrong site
12	Medication	Administration	Medication - wrong site
13	Medication	Administration	Medication - wrong site
14	Medication	Administration	Medication - wrong site
15	Medication	Administration	Medication - wrong site
16	Medication	Administration	Medication - wrong site
17	Medication	Administration	Medication - wrong site
18	Medication	Administration	Medication - wrong site
19	Medication	Administration	Medication - wrong site
20	Medication	Administration	Medication - wrong site
21	Medication	Administration	Medication - wrong site
22	Medication	Administration	Medication - wrong site
23	Medication	Administration	Medication - wrong site

To search by keyword via iGATEWAY at iNTEC: [http://nteciis02/igateway/i Hosp\\_search.aspx](http://nteciis02/igateway/i Hosp_search.aspx)

**Search by Keyword**  
 Hospital = **HO**    Category = **Education**  
 Keyword = **enter keyword**  
 (e.g. DATA, AIRS, SE, SUE, abduction, gauze, guide wire, maternal, message, medication, drugname, suicide, retent wrong patient, wrong site, local risk, global risk)

**iGateway**

(Note: The files information is automatically transmitted from iHosp to this iGateway every 15 mins.)

Filtered by:

Hospital/Organization: ALL HOSPITAL

Department/Specialty: ALL DEPARTMENT

Team: Please Enter Team ID

Category: ALL CATEGORY

Start Date: From To

Review Date: From To

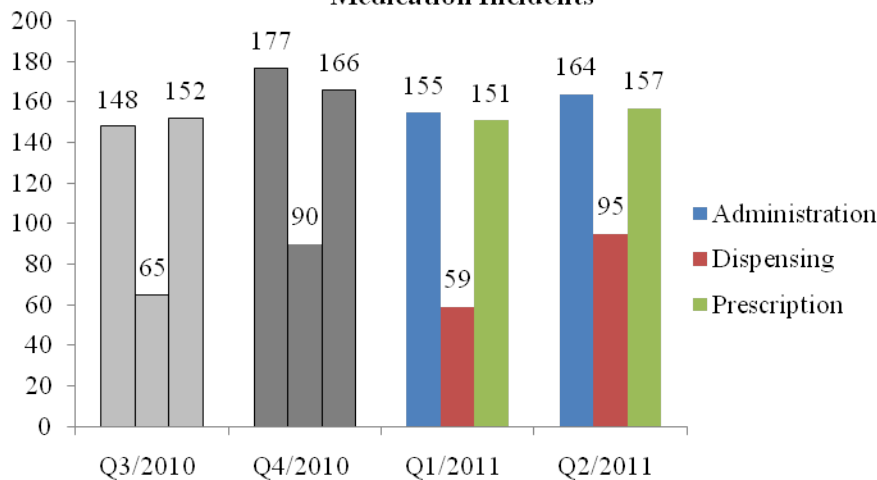
End Date: From To

Title: Please Enter Title

Keyword Search(Title, keywords included): Please Enter Keyword

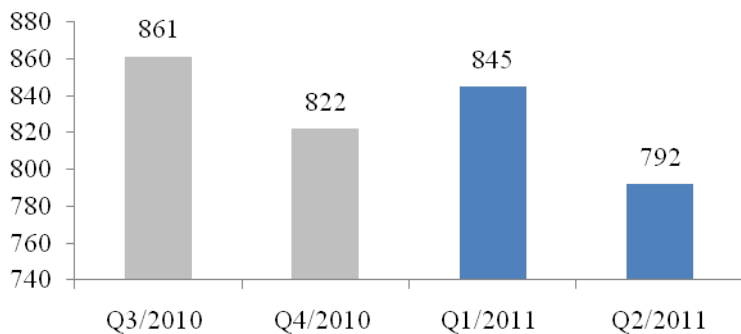
## TOP REPORTED CATEGORIES OF INCIDENTS IN AIRS ((Q1 – Q2 2011))

**Medication Incidents**

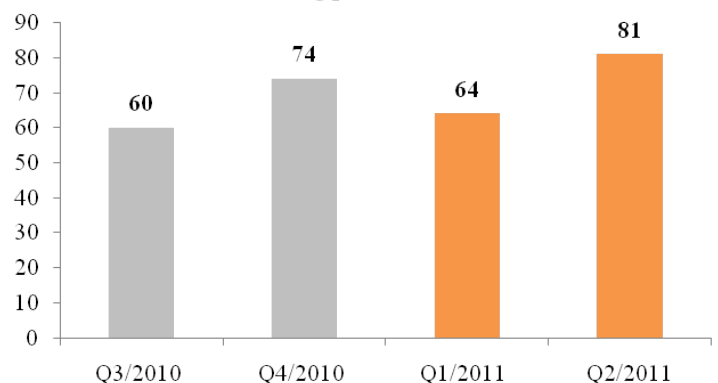


[ #Incident reporting in AIRS is voluntary  
 \* Medication cases include near miss incidents without affecting patients. ]

**Falls**



**Missing patient**



### EDITORIAL BOARD

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Suggestions or feedback are most welcome.

Please email us through HA intranet at address: HO Patient Safety and Risk Management Department

**醫管局嚴重醫療事故數目**  
(二零零七年十月一日至二零一一年九月三十日)

	須呈報的 嚴重醫療事故	二零零七年 十月一日至 二零零八年 九月三十日 (12 個月)	二零零八年 十月一日至 二零零九年 九月三十日 (12 個月)	二零零九年 十月一日至 二零一零年 九月三十日 (12 個月)	二零一零年 十月一日至 二零一一年 九月三十日 (12 個月)
1.	錯誤為病人或某身體部位進行外科手術／介入手術程序	5	10	5	3
2.	進行外科手術／介入手術程序後在病人體內遺留工具或其他物料	10	13	12	18
3.	進行 ABO 血型不配合的輸血	1	0	0	1
4.	錯誤處方藥物引致病人永久喪失主要功能或死亡	0	0	1	1
5.	因出現血管內氣體栓塞而導致病人死亡或神經損害	0	0	1	0
6.	住院病人自殺死亡(包括當時正暫時返家休養的病人)	25	15	11	20
7.	在分娩過程或生產時發生嚴重事件引致孕婦死亡	1	2	2	1
8.	錯配初生嬰兒或發生擄拐嬰兒事件	1	0	0	0
9.	導致病人永久喪失功能或死亡的其他嚴重事件(不包括併發症)	1	0	1	0
	<b>總計</b>	<b>44</b>	<b>40</b>	<b>33</b>	<b>44</b>

**醫管局重大風險事件數目**  
(二零一零年一月一日至二零一一年九月三十日)

	須呈報的重大風險事件	二零一零年 一月一日至 二零一零年 九月三十日 (9 個月)	二零一零年 十月一日至 二零一一年 九月三十日 (12 個月)
1.	錯誤處方藥物事件	72	88
2.	錯辨病人身份事件	9	9